QUICK REFERENCE GUIDE

Prior Authorization

	AETNA	AMERIHEALTH CARITAS	HEALTHY BLUE	LOUISANA HEALTHCARE CONNECTIONS	UNITED HEALTHCARE COMMUNITY PLAN
Prior Authorization Submittal	**Phone**: 1-855-242-0802 Option 2, then Option 1 to reach the PA Department **Physical Health Fax:** 1-844-227-9205 **Behavioral Health Fax**: 1-844-634-1109	By fax to 855-301-5356 or provider portal via Navinet. Call 855-285-7466 with any questions or issues.	Providers may submit an ABA authorization request via: **Phone:** 1-844-521-6942 **Fax:** 1-866-877-5229 Submitting through Availity	Authorization requests can be submitted by fax, phone, or secure web portal and should include all necessary clinical information.	Provider can submit their request for assessment or treatment authorization via fax at 1-888-541-6691 or online portal via Optum Provider Express.
Prior Authorization Transition	Will maintain authorizations until set to expire from Molina.	Prior Authorizations for ABA services approved by Molina prior to February 1, 2018 will remain in effect until they expire. AmeriHealth Caritas of Louisiana will honor all prior ABA authorizations.	All Molina approved prior authorization requests will remain in effect until they expire.	Molina PAs in existence as of Feb. 1, 2018, will be honored until they expire.	All authorizations in place with Molina as of 1/31/2018 will be honored by UHCCP for the authorized timeframe, up to six months.
Prior Authorization Processing Time	Consistent with LDH expectation of 80% within 2 business days and 100% within 14 days, 72 hours when Urgent.	All non-urgent level of care requests must be completed as follows: 80% within 2 business days; 100% within 14 calendar days.	Will follow the TAT's within the current contract.	The MCO must complete 80% of all authorization requests within two business days of receipt and the remaining 20% must be completed within 14 calendar days.	Care Advocates typically respond to providers within two (2) business days from receipt of complete information, as of 80% of decisions are made within two (2) business days and 100% of all decisions are made within fourteen (14) business days.

Updated 12/22/2017

Reconsiderations	Call 855-242-0802 for a Peer to Peer. Must be scheduled within (5) days of receipt of denial notification for services not yet in place.	Providers may call 855-285-7466 to request a reconsideration of a denial or partial denial in services.	Call Provider Services for a Peer-to-Peer (P2P) Discussion. Urgent requests for P2Ps will be handled within the same business day. The provider will be outreached by a Healthy Blue associate to schedule the P2P within (1) business day.	The provider has ten (10) calendar days following the date of the adverse determination to submit a request for an informal reconsideration. The reconsideration will occur within (1) working day of the receipt of the request and shall be conducted between the provider rendering the service and Cenpatico's Medical Director or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within (1) working day. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.	Providers can submit a reconsideration request within 24 hours of notice when an authorization is not approved or needs to be adjusted; a copy of the original decision must be submitted noting it as a reconsideration.
Appeals	Call 855-242-0802 or fax 860-607-7657 For member appeals only – request must be made within 60 calendar days after receipt of NOA. For provider appeals only – request must be made within 30 calendar days after receipt of NOA. We will respond within 30 days of receipt of request. Expedited appeals can be requested in writing and	Providers may request an appeal in writing within 30 calendar days of: the date of the denial or adverse action. Providers will be notified in writing of the appeal determination including the clinical rationale, within 30 calendar days of AmeriHealth Caritas Louisiana's receipt of the request.	Appeals can be filed within 30 days. Standard resolution of appeal is 30 calendar days from the date of receipt of the appeal. Expedited resolution of appeal is 72 hours from the receipt of the appeal.	Appeals may be requested in writing or orally, filed within 30 days from the date of notice of action/inaction, and must be resolved within 30 days. Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal.	Appeals can be filed within 30 days from date of written notice of medical necessity denial. Standard appeals must be resolved in 30 days. Expedited appeals must be completed within 72 hours.

	we respond within 72 hours.				
Prior Authorization Appeals Address	ABHLA Grievance and Appeal Department 2400 Veterans Memorial Boulevard Suite 200 Kenner, LA 70062	Provider Appeals Department P O Box 7324 London, KY 40742	Central Appeals and Grievance Processing Healthy Blue P O Box 62429 Virginia Beach, 23466-2429	Louisiana Healthcare Connections Appeal Department 12515-8 Research Boulevard Suite 400 Austin, TX 78759	United Healthcare Community Plan Appeals & Grievances P O Box 30512 Salt Lake City, UT 84130-051